08514

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:
County Cecil
City or town Colora R.F.D.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Colora R.F.D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Beverly Benjamin

3. (b) Social Security Number

4. Sex female | 5. Color or race white | 6. (a) Single, married, widowed, or divorced Single

B (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1940

8. AGE: Years | Months | Days | If less than one day 3 hrs. min.

9. Birthplace Colora, R.D. Cecil, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Alfred A. Benjamin
13. Birthplace Port Deposit, R.D.

MOTHER
14. Maiden name Ruth Greer.
15. Birthplace Tennessee

16. Informant Alfred Benjamin
Address Colora, Md.

17. Burial Date thereof Aug 7, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hopewell Cem.
Location Port Deposit, Md.

18. Funeral director Lee A. Patterson
Address Perryville, Md.

19. Aug 7 1940 Lynn Whington
(Date rec'd by registrar) Registrar

Permit issued Aug 7-1940

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1940, at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/6 1940, to 8/6 1940, and that I last saw her alive on 8/6 1940.

Immediate cause of death Atelectasis

Due to 7 1/2 months gestation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Dodson M.D.
M. D. or other
Address Rising Sun Md Date signed 8/7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (80-C)

08516

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 1 mo. 3 days

Hospital, institution, or street address where death occurred:
Veterans' Administration

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. --
(If rural, give LOCATION)

2.(a) If veteran, name war: World

3.(a) FULL NAME: BRODERICK, Thomas B.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11, 1887

8. AGE: Years	Months	Days	If less than one day
53	2	21	..... hrs. ..... min.

9. Birthplace: Tralee, Kerry County, Ireland
(Town, county, and state)

10. Usual occupation: Clerk, Electrician

11. Industry or business

FATHER
12. Name: Jeremiah Broderick - deceased
13. Birthplace: Ireland

MOTHER
14. Maiden name: Maggie Kashman - deceased
15. Birthplace: Ireland

16. Informant: Hospital records
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof August 16, 1940 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Ft. Myer, Virginia

18. Funeral director: W.W. Taltavull 2nd Bro.
W.W. TALTAVULL, 2nd & Bro.
Address 3619 - 14th Street, N.W., Washington, D.C.

19. Aug. 16 1940 Irma E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1940, at 11:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1937, to Aug. 16 1940 and that I last saw him alive on August 16 1940

Immediate cause of death	DURATION
Encephalitis, lethargica (non-epidemic)	Unknown
Due to:	
Due to:	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE: C. F. Davis
C. F. DAVIS, M.D., Clinical Director
Address Veterans' Administration, Perry Point, Maryland. Date signed 8-16-40

M.D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 26 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08517

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs. 1 mos. 14 days

Hospital, Institution, or street address where death occurred:
Veterans' Administration

How long in hospital or institution? Same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: None County:

City or town: --
(If outside city or town limits, write RURAL and give nearest town)

Street No.: --
(If rural, give LOCATION)

2.(a) If veteran, name war: World War

3. (a) FULL NAME: CHILLO, Louis

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 15, 1893

8. AGE: Years	Months	Days	If less than one day
47	3	12	..... hrs. ..... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business

FATHER
12. Name: Unknown - deceased
13. Birthplace: Russia

MOTHER
14. Maiden name: Unknown - deceased
15. Birthplace: Russia

16. Informant: Hospital records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 28, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Erin Cemetery

Location: Havre de Grace, Maryland

18. Funeral director: PENNINGTON & SON

Address: Havre de Grace, Md.

19. 8-28- 1940 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1940, at 9:18 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 13 1925, to August 27 1940 and that I last saw h 1m alive on August 27 1940

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, active, far advanced	Unknown
Due to:	
Due to:	
Other conditions: Tuberculosis, genito-urinary tract (Include pregnancy within 3 months of death)	Feb. 1940

Major findings of operations: --

Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of:

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work?

23. SIGNATURE: C. F. Davis

C. F. DAVIS, M.D., Clinical Director

Address: Veterans' Administration, Perry Point, Md. Date signed: 8-28-40

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

08522

CERTIFICATE OF DEATH

Reg. Dist. No. 90

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Cecil Co —

City or town: near Earleville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 2 yrs 2 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Earleville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: near Earleville

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Carl Claussen

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: Annie Mackintosh

6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Dec 7 - 1868

8. AGE: Years	Months	Days	If less than one day
72 —	8	5	____ hrs. ____ min.

9. Birthplace: Swedeen — (Town, county, and state)

10. Usual occupation: Butler

11. Industry or business: —

FATHER — 12. Name: Carl Claussen

FATHER — 13. Birthplace: Swedeen

MOTHER — 14. Maiden name: Fredericka —

MOTHER — 15. Birthplace: Swedeen

16. Informant: Arthur M Enright-Md

Address: Earleville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7. 1940 (month) (day) (year)

Cemetery or crematory: St Stephens

Location: Earleville

18. Funeral director: Wm Coppage

Address: Cecilton Md.

19. Aug 7th 1940 (Date rec'd by registrar) Emma Burke (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 5 1940, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Not attended 19 ____ to ____ 19 ____, and that I last saw h____ alive on ____ 19 ____.

Immediate cause of death	DURATION
Drowning in Patapsco River	
Due to cause unknown was drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 8/5 1940

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John B. Sleem M.D. coroner M. D. or other

Address: Rising Sun Md Date signed: 8/6 1940

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-21)

CERTIFICATE OF DEATH

08523

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Cecil
City or town Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 83-3-7

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town Elkton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Anna Condon

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 27, 1855
8. AGE: Years 83 Months 3 Days 7 If less than one day hrs. min.
9. Birthplace Elkton, Cecil Co. Md (Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Henry S. Condon
13. Birthplace Perryville, Md. R.F.D.
MOTHER 14. Maiden name Martha B. Severing
15. Birthplace Baltimore, Md
16. Informant Wilson L. Condon
Address Perryville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 5, 194 (month) (day) (year)
Cemetery or crematory St Mary's
Location North East, Md
18. Funeral director Lee A. Patterson
Address Perryville, Md
19. August 5 19 40 Irene E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3rd 1940, at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1936, to August 3 1940, and that I last saw h alive on August 1 1940.

	DURATION
Immediate cause of death: Cerebral Haemorrhage.	3da.
Due to: General Atheromata	10 yrs
Due to:	
Other conditions: Cerebral Haemorrhage 1936	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. F. Magraw M. D. or other
Address Perryville Md Date signed 8/3/40

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(92-d)

08521

Reg. Dist. No. 9-2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 502 Bow St

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 4 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 502 Bow St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Beatrice Clark Drew

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Henry Drew

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 30 1876

8. AGE: Years	Months	Days	If less than one day
63	7		hrs. min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Barton Clark
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Mary Miller
15. Birthplace: Kentucky

16. Informant: Miss Grace Drew

Address: 502 Bow St Elkton Md

17. Cremation
(Burial, cremation, or removal. Which?)
Date thereof: Aug 5 1940
(month) (day) (year)

Cemetery or crematory: Silver Brook

Location: Wilmington Del.

16. Funeral director: Florence E Abramson

Address: Elkton R.D. 5 Md

19. Aug 3 1940
(Date rec'd by registrar)

F H Frazier
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 1940, at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1940, to Aug 1 1940, and that I last saw h[illegible] alive on August 1 1940

Immediate cause of death	Chronic endocarditis	8
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. T. Morrison, M.D.
M. D. or other

Address: Elkton, Md Date signed 8-3-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

08515

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County: Cecil Co Md.

City or town: unk.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: unk. County:

City or town: unk. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Mary K. Duncan.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fem	White	Widow

6 (b) Name of husband or wife: Robert Duncan

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov 8 1868

8. AGE: Years	Months	Days	If less than one day
71	9	3	____ hrs. ____ min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Gibson Martin.
13. Birthplace: Penna.

MOTHER
14. Maiden name: No Record
15. Birthplace: XXXXX

16. Informant: Daisy Wright Latter Ret. unk.
Address: Rising Sun Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 14-40 (month) (day) (year)

Cemetery or crematory: Airville

Location: York Co Pa.

18. Funeral director: J. Earl Tyson.

Address: Rising Sun Md.

19. Aug 13 1940 (Date rec'd by registrar) L M Worthington Registrar

Permit issued 8-13-1940

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 1940, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1934, to Aug 11 1940, and that I last saw her alive on August 10 1940.

Immediate cause of death: arteriosclerosis — DURATION: 7 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: F. B. Robinson M.D. M. D. or other

Address: Oxford Penna — Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

CP 08519

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 11 mos. 20 days

Hospital, institution, or street address where death occurred:
Veterans' Administration

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County:

City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1432 N. 18th Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World

3.(a) FULL NAME: FORD, Clarence

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	Widower

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 20, 1895

8. AGE:

Years	Months	Days	If less than one day
45	7	21	hrs. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Teamster

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital records
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: August 12, 1940 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son
PENNINGTON & SON
Address: Havre de Grace, Md.

19. 8-12-40 (Data rec'd by registrar) 19 Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 19 40, at 8:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 19 37, to August 10 19 40 and that I last saw him alive on August 10 19 40

Immediate cause of death	DURATION
General Paralysis of the Insane	Unknown
Due to	
Due to	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE: C. F. Davis
C. F. DAVIS, M.D., Clinical Director
Address: Veterans' Administration, Perry Point, Md. Date signed: Aug. 10, 1940.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

08530

STATE OF MARYLAND
CERTIFICATE OF DEATH

(97)

Registration Dist. No. 94

1 PLACE OF DEATH

County Cecil

Village or City Charlestown (No. ..... St.: ..... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Mary Emma Frederick

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June (Month) 9 (Day), 1861 (Year)

7 AGE: 79 yrs. 2 mos. 13 ds. If LESS than 1 day ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Housewife —
(b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country): Warwick Maryland

PARENTS

10 NAME OF FATHER: William Walmsley

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Harriet Cavinder

13 BIRTHPLACE OF MOTHER (State or Country): Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Frederick

(Address) Charlestown Md

15 Filed Aug 23 1940 Lida V. Owens Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August (Month) 22, (Day) 1940 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 1940 to Aug 22, 1940 that I last saw her alive on Aug 22, 1940, and that death occurred on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH * was as follows:

Arterio sclerosis

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory Secondary: Gangrene y Rt Limb

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) H. Arthur Cornwell M. D.

Aug 22 1940 (Address) North East, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Riverview - Wilm. Del

DATE OF BURIAL: Aug 26, 1940

20 UNDERTAKER: Marshall H. Yeatman

ADDRESS: 819 Washington St Wilmington Del

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 4 1900

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

08524

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton -
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hosp.
Stay in hospital or inst. (yrs., or mos., or days): 7 days.
Stay in this community (yrs., or mos., or days): 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Rural - Maryland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Cecil County Almshouse
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Edith May Gilmore

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: James A. Gilmore
6(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): April 25 - 1887.
8. AGE: Years: 53 Months: 3 Days: 27 If less than one day: ____ hrs. ____ min.
8. Birthplace: Wilmington - Del.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: Samuel Richard Jones
13. Birthplace: Middletown - Md
MOTHER 14. Maiden name: Josephine Faulkner
15. Birthplace: Wilmington - Del
16. Informant: The deceased & Husband
Address: Husband is an inmate of Almshouse
17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 19, 1940 (month) (day) (year)
Cemetery or crematory: Cecil County Almshouse
Location: Cecil County
18. Funeral director: W. W. Pippin
Address: Elkton Md.
19. Aug 19 1940 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1940, at 9 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1923, to Aug 16 1940, and that I last saw h[illegible] alive on Aug 16 1940

Immediate cause of death	Diabetis	DURATION 2 yrs
Due to		
Due to		
Other conditions	Gangrene L Leg	10 days

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the [illegible] to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: T. H. McKnight M.D.
M. D. or other
Address: Elkton - Md Date signed: 8/16/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

08525

Reg. Dist. No. 97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Rural near Elkton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R F D 2
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Curtis M. Little

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 4 1929

8. AGE: Years	Months	Days	If less than one day
11	6	24	hrs. min.

9. Birthplace: Rising Sun Cecil Md (Town, county, and state)
10. Usual occupation: at School
11. Industry or business:

FATHER
12. Name: Norman Little
13. Birthplace: Bel Air, Md

MOTHER
14. Maiden name: Aretha Reed
15. Birthplace: Roanoke, Va

16. Informant: Norman Little
Address: Elkton Md R D 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 31 1940 (month) (day) (year)
Cemetery or crematory: Johnstown
Location: Earleville Cecil Co Md
18. Funeral director: H. W. Pippin
Address: Elkton, Md

19. Aug 31 1940 (Date rec'd by registrar) H. H. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28th 1940, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dr Bales 8/21 1940, to Aug 25 1940, and that I last saw h alive on 19

Immediate cause of death	DURATION
Fractured Skull	4 days
Due to Falling from Swing	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Fractured Skull and lacerated brain from bone fragments in
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8/21 1940
Where did injury occur? Charlestown (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?): Public Place
Means of injury: Falling from Swing Injured at work?

23. SIGNATURE: John B. Shaw M D
M. D. or other
Address: Rising Sun Md Date signed: 8/25/1940

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08528

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Cecil
City or town Charlestown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State New York County Queens Co.
City or town Lindenhurst, L.I. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 161 - 33rd St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas J. J. Malcolm

3. (b) Social Security Number 709-10-1545

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Madeline M. Malcolm
6(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): Oct 17, 1884.
8. AGE: Years 55 | Months 9 | Days 24 | If less than one day: hrs. min.
9. Birthplace: Perryman, Harford, md
10. Usual occupation: Pullman Conductor
11. Industry or business: Rail Road
FATHER 12. Name: Frank P. Malcolm
13. Birthplace: Perryman, Harford Co, md
MOTHER 14. Maiden name: Abbie G. Dudley
15. Birthplace: Portland, Maine
16. Informant: Madeline M. Malcolm
Address: 161 - 33rd St Lindenhurst, L.I. N.Y.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 12, 1940 (month) (day) (year)
Cemetery or ~~crematory~~: Presentia
Location: Perryman, Harford Co, md
18. Funeral director: Lee A. Patterson
Address: Perryville, Md.
19. August 11 1940 (Date rec'd by registrar) Irma E. Daugherty. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1940, at 6.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10 1940, to Aug. 10 1940, and that I last saw him alive on Aug. 10 1940.

	DURATION
Immediate cause of death: Coronary Thrombosis	1 hr
Due to: Chronic Valvular Heart disease	8 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ~~and~~ Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. F. Magraw M. D. or other
Address Perryville Md Date signed Aug. 01940

RECEIVED
AUG 16 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(8)

08534

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Cecil

City or town Perryville Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Perryville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Still Birth Martini

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24 1940

8. AGE: Years Still Birth Months Days If less than one day hrs. min.

9. Birthplace Perryville Md (Town, county, and state)

10. Usual occupation Still Birth

11. Industry or business

FATHER 12. Name Ralph Martini

13. Birthplace Aprigliano, Cosenza, Italy

MOTHER 14. Maiden name Maryanna Calao

15. Birthplace Pizzinde Caserta Italy

16. Informant Ralph Martini

Address Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 25, 1940 (month) (day) (year)

Cemetery or crematory Joe Preuss

Location

18. Funeral director Lee A. Cattelroy.

Address Perryville, Md.

19. Aug 25 1940 Irene Daugherty (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1940, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1940 to Aug 24 1940, and that I last saw h Still on Still Birth 19

Immediate cause of death	DURATION
Premature Separation of Placenta	1 da
Due to Faulty Foetal Development	4 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Maguire M. D. or other

Address Perryville Md Date signed 8/25/40

RECEIVED
SEP 4 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08518

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 3 days

Hospital, institution, or street address where death occurred:
Veterans' Administration

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: South Carolina County:

City or town: Plum Branch
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World

3.(a) FULL NAME

NELSON, George

3.(b) Social Security Number

578-14-5353

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	Widower

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 10, 1896

8. AGE: Years	Months	Days	If less than one day
44	0	23	..... hrs. ..... min.

9. Birthplace: Greenwood, S.C.
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business

FATHER 12. Name: Gilroy Roane

13. Birthplace: Unknown

MOTHER 14. Maiden name: Annie (?)

15. Birthplace: Unknown

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 5, 1940 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland.

18. Funeral director: Pennington & Son
PENNINGTON & SON

Address: Havre de Grace, Md.

19. Aug. 3, 1940 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2, 1940 at 8:05 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 30 1940, to Aug. 2, 1940 and that I last saw him alive on August 2 1940

Immediate cause of death	DURATION
General Paralysis of the Insane	Unknown
Due to	
Due to	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE: C. F. Davis M.D. or other
C. F. DAVIS, M.D., Clinical Director
Address: Veterans' Administration Date signed: 8-3-40
Perry Point, Maryland.

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

08532

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County Cecil

City or town Calvert, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Calvert Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. —

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME William Thomas Ramsey

3. (b) Social Security Number None

4. Sex male

5. Color or race white

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Bertha Ramsey

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 5, ~~1940~~ 1870

8. AGE: Years 70 Months 2 Days 3 If less than one day ____ hrs. ____ min.

9. Birthplace Ohio (Town, county, and state)

10. Usual occupation Sexon

11. Industry or business Cemetary

FATHER 12. Name William T Ramsey

13. Birthplace Ohio.

MOTHER 14. Maiden name Did not know

15. Birthplace

16. Informant Bertha Ramsey

Address Rising Sun, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-11-1940 (month) (day) (year)

Cemetery or crematory Rosebank

Location Calvert, Md.

18. Funeral director Ralph M Reed

Address Rising Sun, Md.

19. Aug 8 1940 (Date rec'd by Registrar) Lynn Whittington Registrar

Permit issued 8-10-1940

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1940, at 3 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/31 1940, to 8/8 1940, and that I last saw h in alive on 8/4 1940.

Immediate cause of death Cerebral Myocarditis

Due to Arteriosclerosis & Paralysis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations —

Dt autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE R. C. Dockson. MD M. D. or other

Address Rising Sun Md Date signed 8/8-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a)

08527

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:
County Cecil
City or town Rising Sun, Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 88

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Rising Sun, Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry T. Reynolds.
3. (b) Social Security Number none.

4. Sex Male
5. Color or race white
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Anna M. Reynolds
6(c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) Jan. 12, 1852
8. AGE: Years 88 Months 7 Days 16 If less than one day hrs. min.
9. Birthplace Rising Sun, Cecil co. Md
(Town, county, and state)
10. Usual occupation Farmer.
11. Industry or business owner
FATHER 12. Name Samuel Reynolds
13. Birthplace Cecil co. Md
MOTHER 14. Maiden name Susan McVey.
15. Birthplace Lancaster co., Pa
16. Informant Anna M. Reynolds
Address Rising Sun, Md. R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 1, 1940 (month) (day) (year)
Cemetery or crematory Bayview cem.
Location Bayview, Cecil co., Md
18. Funeral director Lee A. Patterson
Address Perryville, Md.
19. Aug 30 1940 (Date rec'd by registrar) L. M. Worthington Registrar
Permit issued 8-30-1940.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1940, at 5 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1940 to Aug 28 1940, and that I last saw him alive on 8/22 1940.
Immediate cause of death Chronic Interstitial
Due to Nephritis
Due to Arteriosclerosis
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. C. Dodson M. D. or other
Address Rising Sun Md Date signed 8/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(83-02)

08529

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Cecil

City or town Fredericktown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Fredericktown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Addie M Riggin

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Norman L. Riggin

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 10th 1876

8. AGE: Years 64 | Months 1 | Days 6 | If less than one day ___ hrs. ___ min.

9. Birthplace Georgetown Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name L. R. Nordall

13. Birthplace Georgetown Md

MOTHER

14. Maiden name Ella Medders

15. Birthplace Galena Md

16. Informant N. L. Riggin

Address Georgetown Md

17. Presbyterian Georgetown Md (Burial, cremation, or removal. Which?) Date thereof Aug 19 1940 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Georgetown Md

18. Funeral director Jno Coppage

Address Cecilton Md

19. Aug 17th 1940 (Date rec'd by registrar) Irving Burke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1940, at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from not attended, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Cerebral Hemorrhage

Due to Chronic Arthritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John D. Glesse M.D. Coroner M.D. or other

Address Pleasy Sun Md Date signed 8/16 1940

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08526

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County: New Castle
City or town: Elkton Md RD 2 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Lillie A. Smith

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife: John Smith

6(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Aug 2 1891

8. AGE:

Years	Months	Days	If less than one day
49		1	hrs. min.

8. Birthplace: Glasgow New Castle Delaware (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Robert Black
13. Birthplace: Glasgow Delaware

MOTHER
14. Maiden name: Emma Lewis
15. Birthplace: Upland Pa

16. Informant: John Smith
Address: Elkton Md RD 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6 1940 (month) (day) (year)

Cemetery or crematory: St Thomas Cemetery

Location: near Glasgow Delaware

18. Funeral director: H. W. Pippin

Address: Elkton Md

19. Aug 5 1940 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: (July) 3rd August 1940, at 1020 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__ and that I last saw h__ alive on ____ 19__

Immediate cause of death: Coronary Thrombosis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: John D. Shiem M D
M. D. or other

Address: Shaky Sure M D Date signed 8/30/1940

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08520

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66 days

Hospital, Institution, or street address where death occurred:

Veterans' Administration

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3446 Highwood Drive

(If rural, give LOCATION)

2.(a) If veteran, name war: World War

3.(a) FULL NAME: THOMAS, James

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Mrs. Edith I. Thomas

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50	5	16	hrs. min.

9. Birthplace: Indianapolis, Ind.

(Town, county, and state)

10. Usual occupation: Rigger - Navy

11. Industry or business:

FATHER

12. Name: Unknown - deceased

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital records

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 13, 1940 (month) (day) (year)

Cemetery or crematory: Unknown

Location: Washington, D.C.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. 8-12- 1940 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 1940 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3, 1940 Admitted to hospital

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Sclerosis	Unknown
Due to	
Due to	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE: John B. Sticer M.D. or other

JOHN B. STICER, M.D., Coroner

Address: Rising Sun, Md. Date signed 8-12-40

RECEIVED
AUG 20 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94B)

08531

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Arthur McCullough Tosh

3. (b) Social Security Number

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Maude Tosh

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 11. 1865

8. AGE: Years 75 Months 4 Days 8 If less than one day ..... hrs. ..... min.

9. Birthplace: Colora Md.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Joseph Tosh

13. Birthplace: Md.

MOTHER

14. Maiden name: Annie McCullough

15. Birthplace: Md.

16. Informant: Mrs. Maude Tosh

Address: Rising Sun. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 22. 1940 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Near Colora

18. Funeral director: J. E. Tyson

Address: Rising Sun. Md.

19. Aug. 21 1940 (Date rec'd by registrar) Lon Worthington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19 1940, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/19 1940, to 8/19 1940 and that I last saw him alive on 8/19 1940

Immediate cause of death: Angina Pectoris Acute

Due to:

Due to: Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. C. Dodson MD M. D. or other

Address: Rising Sun Md Date signed: 8/21-40

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

08533

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Cecil

City or town Mechanic Valley
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County Grayson County

City or town Summerfield Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR not a Veteran

3. (a) FULL NAME John M. Vaughan

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Caroline Vaughan

6(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Feb 2 1853

8. AGE:

Years	Months	Days	If less than one day
87	6	16	hrs. min.

9. Birthplace Spring Valley, Va
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name David Vaughan

13. Birthplace Va

MOTHER 14. Maiden name Not known

15. Birthplace

16. Informant Mrs Howard Heath

Address North East, R. D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21, 1940 (month) (day) (year)

Cemetery or crematory Summerfield Cemetery

Location Grayson County, Va

18. Funeral director Joseph R. Glaus

Address North East, Md.

19. Aug 9 1940 (Date rec'd by registrar) Lida E. Crouse Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1940, at 6 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1939, to Aug. 18 1940, and that I last saw h is alive on Aug. 12 1940

	DURATION
Immediate cause of death Uremia	
Due to Cardio-vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

20 operations —

20 autopsy Yes.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bruford N. Buckley M.D.
M. D. or other

Address Elkton, Md Date signed Aug. 19, 1940

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

CERTIFICATE OF DEATH

08535

Reg. Dist. No. 92

1. PLACE OF DEATH:
County Cecil
City or town Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Port Deposit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Dorsie Weggins

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): August 3 - 1940
8. AGE: Years | Months | Days | If less than one day: 20 hrs. min.
9. Birthplace: Port Deposit, Cecil, Maryland (town, county, and state)
10. Usual occupation: None
11. Industry or business: None
12. FATHER Name: William Frank Weggins
13. FATHER Birthplace: Pennsylvania
14. MOTHER Maiden name: Margaret Jean Moulton
15. MOTHER Birthplace: Maryland
16. Informant: Mrs. Margaret Weggins
Address: Port Deposit Md
17. Burial (Burial, cremation, or removal. Where?) Date thereof: Aug 5 1940 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora Md.
18. Funeral director: J. E. Tyson
Address: Rising Sun Md.
19. Aug 4 1940 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1940, at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 1940, to Aug 4 1940, and that I last saw him alive on Aug 3 1940.

Immediate cause of death: Lyndergloved Atelectasis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE R L Dodson M.D.
M. D. or other
Address Rising Sun Md. Date signed Aug 4-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.